

PRIME 400 LLC
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Nevada City, California 95959

Notice of Independent Review Decision

DATE OF REVIEW: NOVEMBER 25, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of physical therapy three times a week for four weeks, lumbar.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

MD, Board Certified Orthopedic Surgeon

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity does not exist for physical therapy three times a week for four weeks, lumbar.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 10/07/08 and 10/21/08
ODG Guidelines and Treatment Guidelines
Office Notes, Dr. , 1/29/07, 12/23/07, 02/22/08 and 10/24/08
MRI Report: 02/19/08
Therapy Note: 09/24/08 and 11/03/08
Patient Questionnaire: 09/24/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year-old male who was involved in a motor vehicle accident on xx/xx/xx. The first record provided for review was dated 11/29/07 with a notation that the claimant had been seen in the emergency room and told nothing was broken. The claimant primarily complained of axillary low back pain with no numbness or tingling. Physical examination demonstrated minimal tenderness, full motion with some terminal discomfort and intact motor, reflex and sensation findings. Reference was made to negative lumbar radiographs. The claimant treated was diagnosed with myofascial pain and treated with a muscle relaxer, anti-inflammatories, pain medication and lumbar corset. Reevaluation on 12/23/07 reported some improvement with notation of no tenderness with full motion.

However, the claimant did complain of some numbness and tingling in the bilateral lower extremities and MRI evaluation was ordered. A lumbar MRI was performed on 02/19/08 with no abnormalities identified. On 02/22/08 Dr. noted improving myofascial pain and recommended physical therapy. There was a gap in records between 02/22/08 and 09/24/08. The claimant attended a physical therapy evaluation on 09/24/08 with notation of an evaluation being completed in April 2008 with no treatment rendered. On 09/24/08 the claimant reported continued low back pain with no associated paresthesias. Dr. saw the claimant on 10/24/08 with notation the myofascial pain was improving with physical therapy and therapy was continued. A therapy note on 11/03/08 indicated completion of thirteen therapy sessions with a statement that the claimant wanted to progress to a home exercise program. Twelve therapy sessions have been requested.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

Based on the records provided for review the requested lumbar physical therapy three times a week for four weeks would not be recommended as medically necessary.

The records indicate that the claimant sustained primarily soft tissue low back complaints. There is documentation of normal radiographs and MRI evaluation. The claimant has completed thirteen sessions of therapy with an expressed interest in progressing to a home exercise program. Physical examination on 10/24/08 failed to identify any significant spasms or functional limitations that would benefit from continued formal therapy. Official Disability Guidelines support ten therapy visits for the diagnosis of lumbar strain. The claimant has already exceeded this recommendation with reported improvement; functional motion and strength; and interest in pursuing an independent regimen. There is no indication that formal therapeutic management would offer the claimant any additional benefit for subjective complaints of pain. Based solely on the records provided, additional therapy would not be considered medically appropriate. The reviewer finds that medical necessity does not exist for physical therapy three times a week for four weeks, lumbar.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates; Low Back-Physical Therapy

Lumbar sprains and strains (ICD9 847.2):

10 visits over 8 weeks

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)